VAN ZANDT COUNTY HIGH PRIDE PROGRAM

Residential Placement Packet Checklist

All items must be completed before the juvenile's admission into the High Pride Program.

Juvenile	Date	Date and Time of Admission Into High Pride Program

COPY OF: (Put in Date of All Paperwork)

_____1. SOCIAL HISTORY & OFFENSE REPORT

_____2. COPY OF CURRENT COURT ORDER

_____3. INTERAGENCY APPLICATION FOR PLACEMENT (LEVEL OF CARE)

_____4. CURRENT PHYSICAL (Within 90 days prior to admissions)

_____5. CURRENT DENTAL (Within 180 days prior to admissions)

_____6. HAIR CUT PRIOR TO ENTRY OR $15 PROVIDED FOR HAIRCUT PRICE

_____7. PSYCHOLOGICAL (Shall minimally include) (365 days prior to admissions)

(a) The results of any personality assessment
(b) Youth's cognitive ability, including IQ score
(c) Axis I – V Diagnosis
(d) Summary of Findings and Recommendations-needs to reflect that the child is in need of residential treatment.
(e) Doctor's signature

_____8. SCHOOL RECORDS

_____9. IMMUNIZATION RECORD (Must be up-to-date and documented)

_____10. CURRENT TUBERCULOSIS TEST AND RESULTS (365 days prior to admissions)

_____11. COPY OF SOCIAL SECURITY CARD

_____12. COPY OF BIRTH CERTIFICATE

_____13. MEDICAL INSURANCE INFORMATION

_____14. MEDICAL RELEASE

_____15. CONSENT TO PARTICIPATE IN PROGRAM RELEASE

_____16. LIST OF APPROVED VISITORS

_____17. APPROVED MAILING LIST

_____18. MAYSI 2 SCREENING USED ON REFERRING OFFENSES

_____19. NOBLE PACT: FULL SCREENING ASSESSMENT

_____20. INITIAL SECURE CASE PLAN (Must be completed by home county within 30 days of placement)

_____
SIGNATURE OF PLACEMENT OFFICER

MEDICAL AND PHYSICAL EXAMINATION FORM

NAME :_____ SEX : (CIRCLE ONE) M/F

PARENT OR GUARDIAN NAME :_____

ALL BLANK SPACES MUST BE COMPLETED

WEIGHT_____HEIGHT_____ PULSE_____ BLOOD PRESSURE_____

LEGEND: N = NORMAL X = ABNORMAL NE= NOT EXAMINED
GENERAL BODY BUILD _____ SKIN _____
EYE_____ EAR_____ NOSE_____ THROAT_____TEETH_____
NECK_____ LUNGS_____ HEART_____ CHEST _____LIVER_____
SPLEEN_____ SPINE_____ABDOMINAL MASSES_____

JOINT FUNCTION: NECK_____ SHOULDERS_____
ELBOWS_____ WRISTS_____
HANDS _____ HIPS_____ KNEES_____
ANKLES_____ FEET_____
NEUROLOGICAL_____ HERNIA_____ GENITALIA_____
(MALE ONLY)

TB TEST DATE_____ DATE OF TEST READ_____
RESULTS OF TB TEST_____
OPTIONAL AT DISCRETION OF PHYSICIAN:
HGB OR HEMATOCRIT_____
URINALYSIS_____
DESCRIPTION OF ABNORMAL FINDINGS_____

DATE OF EXAM_____
PRINTED /TYPED NAME OF PHYSICIAN
PHYSICIAN'S ADDRESS/TELEPHONE

_____
_____
_____

SIGNATURE OF PHYSICIAN _____

PARENT/GUARDIAN CONSENT FOR MEDICAL, DENTAL, PSYCHOLOGICAL & TREATMENT

Name of Child, a minor:_____
Name of Parents: _____
Name of Managing Conservator or Guardian, if any: _____
Name of Person giving consent: _____
Relationship of person giving consent for minor (circle your relationship to the minor) PARENT LEGAL GUARDIAN ADULT
TEXAS FAMILY CODE- SECTION 32.001 (A)(5), relationship: _____, with the document copy attached:

1. I have authority to consent to medical, dental, psychological, and surgical services and treatment for this minor.
2. I know and agree what when this document says VZCJPD, the Van Zandt County Juvenile Probation Department may act through Director of Juvenile Services, Robert Colacino, and the designated Health Care Services employees under his direction.
3. I consent to medically necessary medical, dental, psychological, and surgical services and treatment for this minor for the period of custody beginning _____, 20____ in the VZCJPD Probation Department, Detention Center or Residential Facility.
4. I provide the information about medical and dental benefit plans and insurance for use if services or treatment are needed. In all other cases, this information is confidential, unless I consent to the release of the information for other uses.
5. I authorize the medical provider to provide this minor with medically necessary X-ray examination, laboratory testing, anesthetic, medical, surgical, dental procedure or treatment and hospital care. The procedures, treatment and care must be provided under the general supervision and on the advice of a physician or dentist licensed by the laws of Texas.
6. I authorize the VZCJD to obtain medically necessary X-ray examination, laboratory testing, anesthetic, medical surgical, dental procedure or treatment and hospital care for this minor, and to administer medication and treatment to this minor as directed and as prescribed by a licensed physical or dentist.
7. I consent to medical, psychological and dental providers releasing to the VZCJPD the information regarding the services, treatment, and medication provided the minor during custody; and VZCJPD is authorized to receive the information as needed.
8. I understand that I may revoke any or all of the provisions of this document, except to the extent that action has been taken in reliance on it, if I give a written and signed document to VZCJPD describing the provision(s) to be revoked.

_____ _____
Signature of Authorizing Consenting Person Date

_____ _____
Phone # Home Work Address

Is the child covered by a medical and/or dental benefit plan, insurance company, Medicaid, etc? _____ If "Yes" give:
Responsible party(s) carrying coverage: _____ S.S. # _____
Employer: _____ Primary Physician: _____
Insurance Company/HMO/PPO: _____
Group/Policy Number: _____ Address of Claim Office: _____

Medicaid PCA #: _____ Primary Physician: _____
Medicaid HMO Blue#: _____ Primary Physician: _____
Medicaid Foundation Health #: _____ Primary Physician: _____

_____ _____
Signature of Authorizing Consenting Person Date

_____ _____
Phone # Home Work Address

I, _____ **print name legibly,** position _____ have given an explanation of the consents and authorizations to the person stated in "Person giving consent". The person verbally gave me the consents and authorizations on this form as he/she as not available in person to execute this form as required by VZCJPD. The person has authorized me to enter the above information. I requested the person to appear and sign this form.

Signed: _____ Date/Time:_____

VAN ZANDT COUNTY JUVENILE PROBATION DEPARTMENT
MEDICAL AUTHORIZATION

Name of Child_____
Name of Parent/ Legal Guardian_____
Name of Person Giving Consent_____

I do further, hereby request and authorize the staff of the Van Zandt County Juvenile Probation Department/Detention Center to give prescription medication to my child as ordered by a licensed physician. Non-prescription medication may be administered to my child, as needed at the discretion of probation and/or detention personnel.

I do hereby agree to save, hold harmless and indemnify the Van Zandt County Juvenile Probation Department/Detention Center of and from any all claims, demands, and causes of action whatsoever on account of or in any way resulting from or to result from the authorizing by the Van Zandt County Juvenile Probation Department/Detention Center of such medical services.

Non-Prescription Medications:

Authorized:	Staff Initials	Parent/Guardian Initials
Ibuprofen	_____	_____
Pink Bismuth	_____	_____
Non-Aspirin Pain Reliever	_____	_____
Triple Antibiotic Ointment	_____	_____
Hydrogen Peroxide	_____	_____
Calamine Lotion	_____	_____
Vaseline	_____	_____
Other	_____	_____
Isopropyl Alcohol (sanitization/sterilization only)	_____	_____

Prescription Medications: (list all Meds)_____
_____
Physician Name:_____ Phone Number:_____
Known Allergies:_____
Known Serious Mental Illness Diagnosis(psychoses, schizophrenia, bipolar-depression/psychotic features, severe post-traumatic stress disorder, schizoaffective disorders) _____ Yes ____No If yes please list:_____
Parent/ Legal Guardian Signature _____Date/Time_____

Van Zandt County Juvenile Supervision Officer **(Circle One)** Received / or Witnessed Signed Consent Form

_____J.S.O Date/Time_____

****
********I, _____(PRINT NAME LEGIBLY), position _____
have given an explanation of the contents and authorization on this form as he/ she as not available to the person stated in "Person giving consent". The person verbally gave me the consents and authorizations on this form as he/she as not available in person to execute this form as required by Van Zandt county Juvenile Probation Department. The person has authorized me to enter the above information. I requested the person to appear and sign this form.

Signed_____ Date/Time:_____
(Medical Authorization.word.paul)

VAN ZANDT COUNTY JUVENILE PROBATION DEPARTMENT
HIGH PRIDE PROGRAM
APPROVED INCOMING MAIL LIST/OUTGOING MAIL LIST

APPROVED INCOMING MAIL LIST:

NAME	RELATIONSHIP	ADDRESS

APPROVED OUTGOING MAIL LIST:

NAME	RELATIONSHIP	ADDRESS

(RANDY/HIGH PRIDE/HIGH PRIDE PACKET/HP APPROVED MAILING LIST. Word)

VAN ZANDT COUNTY JUVENILE PROBATION DEPARTMENT
HIGH PRIDE PROGRAM
APPROVED VISITATION LIST / APPROVED PHONE AUTHORIZATION LIST

APPROVED VISITATION LIST:

NAME	RELATIONSHIP	PHONE NUMBER

APPROVED PHONE AUTHORIZATION LIST:

NAME	RELATIONSHIP	PHONE NUMBER

(RANDY/HIGH PRIDE/HIGH PRIDE PACKET/visitation/phone authorization High Pride list. Word)

VAN ZANDT COUNTY JUVENILE PROBATION DEPARTMENT

HIGH PRIDE PROGRAM

CONSENT TO PARTICIPATE IN PROGRAM

In connection with the Van Zandt County Juvenile Probation Department High Pride Residential Treatment Program, we the undersigned parents or guardian of _____, minor understand and agree that participation in this program by my child will involve a wide variety of Programs that will consist of but not limited to camping trips, fishing trips, outings in the park, extra-curricular activities at the school, work assignments, attend movies, etc. and do hereby release and agree to hold harmless the Van Zandt County Juvenile Probation Department, it's employees, agents, and/or affiliates from and against any clam for personal injuries or damages that might arise out of our child's participation in this program, or any alleged negligence on their part for conducting the program or allowing us or our child to participate in it.

_____

Signature of Parent/Guardian Date

_____

Witness Date